MARYLAND TRAUMA PHYSICIAN SERVICES FUND

Semi-Annual Uncompensated Care

Physician Payment Application

Electronic Submission

MARYLAND HEALTH CARE COMMISSION

Stephen J. Salamon
Chairman

Rex W. Cowdry, M.D.
Executive Director

HEALTH SERVICES COST REVIEW COMMISSION

Irvin W. Kues
Chairman

Robert Murray
Executive Director

CONTACT INFO… William D. Chan, Health Policy Analyst

410-764-3374 or trauma@mhcc.state.md.us

Revised June 14, 2006

You ARE eligible

IF . . .

- You are a trauma surgeon, orthopedic surgeon, neurosurgeon, critical care physician, anesthesiologist, or emergency room physician.

- You are a physician credentialed on the Trauma Center's roster of participating physicians at the time when services were provided.

- You provide trauma services to a trauma patient in a MIEMSS designated Trauma Center.

- You provide services to a trauma patient with no health insurance, including Medicare Part B coverage, VA health benefits, CHAMPUS, Worker's Compensation, and is not eligible for Medical Assistance coverage. The trauma physician can submit an application to the Fund for services provided to uncompensated care patients once he/she has exhausted their attempts to collect payment using the trauma physician's documented collection policies and procedures.

- You provide services to a trauma patient with a Maryland Trauma Registry Number.

Please remember…

- Any services previously claimed under the Fund are not eligible.
- Applications are due twice a year by the end of January or July.

1. Application Submission Date:

Month Day Year

2. Rendering Physician Information:

Name of physician, practice, or center

Street Address

City State

Zip Code Area Code + Telephone Number

E-mail Address

3. Contact person if additional application information is needed:

Name Title

Street Address

City State

Zip Code Area Code + Telephone Number

E-mail Address

4. Trauma Center where care was provided:

Trauma Center Name

5. **Remittance Information.** The Office of the Comptroller will issue one disbursement check to the individual listed in this question.

Name Title

Street

City State Zip Code

6. How many cases were written-off to a collection agency by the faculty or physician practice during this reporting period?

   What is the dollar amount written-off to a collection agency by the faculty or physician practice during this reporting period? Base response on gross charges.

   $

7. During this reporting period, was money recovered from another payer source for past services declared and reimbursed under the Fund? You need only report the amount paid to you by the Fund. MHCC will reduce your overall payment by this amount.

   $

TABLE 1 Financial Information

Please report Accounts Receivables for Trauma Patients as of May 2006.

Trauma Patient Payment Source	Billed Amount May 1st – 31st	Total Open Receivables
Self-Pay		
Medical Assistance		
Medical Assistance Pending		
Medicare		
Other Payment Sources		
TOTAL		

TABLE DEFINITIONS -- FINANCIAL INFORMATION

Trauma Patient Payment Source – Type of payer for trauma patients only.

Other Payment Sources – Remaining trauma patient payment sources, including private health insurers, VA Health Benefits, CHAMPUS, TriCare, Worker's Compensation, and auto insurance carriers.

Billed Amount May 1st – 31st – Amount billed by trauma physician for trauma services provided to trauma patients during the month of May.

Total Open Receivables –- Total trauma patient accounts receivables through May 31st.

VERIFICATION

PHYSICIAN UNCOMPENSATED CARE LOSSES INFORMATION

I hereby certify that the facts stated in the Maryland Trauma Fund Semi-Annual Uncompensated Care Application are accurate and true to the best of my knowledge and that the faculty or physician practice followed and adhered to its established collection policies and procedures before submitting this application to the Maryland Trauma Physician Services Fund.

(Name of Physician Practice or Group - please print or type)

(Physician Group Designee's Name & Title – please print or type)

(Physician Group Designee's Authorized Signature)

(Date)

VERIFICATION

TRAUMA CENTER INFORMATION

I hereby certify on behalf of the Trauma Center that (1) the Trauma Patients reported in this Application are on the Maryland Trauma Registry, (2) the Physician is credentialed by the Hospital as a Trauma Physician, and (3) that the Trauma Patient received care in the Trauma Center, or the acute care hospital associated with the Trauma Center, on the dates reported.

(Name of Trauma Center/Hospital - please print or type)

(Trauma Center Administrator's Name & Title – please print or type)

(Trauma Center Administrator's Signature)

(Date)

Appendix A

Facility ID # -- Please use the following facility identification numbers to identify the location of the trauma center on your Excel spreadsheet.

Trauma Center	Facility ID #	Trauma Center	Facility ID #
Johns Hopkins Bayview Medical Center (Adult Trauma Center)	01	R. Adams Cowley Shock Trauma Center	34
Johns Hopkins Hospital (Adult Trauma Center)	04	Suburban Hospital (Adult Trauma Center)	49
Peninsula Regional Medical Center (Adult Trauma Center)	08	Washington County Hospital (Adult Trauma Center)	89
Sinai Hospital (Adult Trauma Center)	10	Johns Hopkins Medical Center (Pediatric Trauma Center)	05
Western Maryland Health System (Adult Trauma Center)	20	Children's National Medical Center (Pediatric Trauma Center)	17
Prince George's Hospital Center (Adult Trauma Center)	32		

PLEASE RETURN APPLICATION TO:

Mr. William D. Chan
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore MD 21215

PLEASE COMPLETE THE INFORMATION
VERIFICATION FORMS
ON THE PRECEDING PAGES
SUBMIT VERIFICATION FORMS WITH COMPLETED APPLICATION.

THANK YOU.